Frank O'Bannon, Governor
State of Indiana

Children's Health Insurance Program
402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

Peter A. Sybinsky, Ph.D., Secretary
Family and Social Services Administration

March 27, 2000

Faith Covici
Region V
HCFA, DMSO
233 N. Michigan Ave., Suite 600
Chicago, IL 60601

Dear Ms. Covici:

Please find enclosed a copy of the evaluation of Indiana's Children's Health Insurance Program (CHIP) as required by Section 2108(b) of the Social Security Act. The evaluation reflects the period beginning with implementation of Indiana's state plan and ending Federal Fiscal Year 1999 (October 1, 1997 through September 30, 1999). Indiana has utilized the evaluation framework developed by the National Academy for State Health Policy.

We believe that the enclosed evaluation accurately depicts the tremendous success that Indiana has achieved with the enrollment of targeted, low-income children in Hoosier Healthwise, Indiana's managed care program for Medicaid and CHIP. With the implementation of CHIP in Indiana, aggressive outreach strategies were initiated to remove the stigma associated with Hoosier Healthwise, make it easier for families to apply and participate, and encourage community participation and collaboration.

Indiana plans to build on the accomplishments of CHIP to examine the possibility of providing health coverage to families of targeted low-income children. We look forward to working with HCFA on these future endeavors.

Sincerely,

Nancy Cobb, Director
Children's Health Insurance Program

cc: Jennifer Ryan

FRAMEWORK FOR STATE EVALUATION OF CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

State/Territory: State of Indiana

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

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(Signature of Agency Head)

Date: March 31, 2000

Reporting Period: October 1, 1997 to September 30, 1999

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SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

As indicated in our State Plan, prior to implementation of the Title XXI program, we estimated that the total number of uninsured children in Indiana was approximately 173,000. Approximately 129,000 of these children were below 200% of the federal poverty level.

The State also estimated that there were approximately 55,000 children in Indiana who were already eligible for Medicaid but were not enrolled in the program. An additional 36,000 uninsured children became eligible for Medicaid as a result of the 1998 Title XXI Medicaid expansion.

1.1.1 What are the data source(s) and methodology used to make this estimate?

The estimate of the total number of uninsured children in Indiana prior to implementation of the Title XXI program was based on the uninsured rates calculated from the 1995 and 1996 Current Population Survey (CPS) by the Urban Institute.

The estimates of the number of uninsured children below 200% of the federal poverty level, the number of children already eligible for Medicaid but not enrolled, and the number of children eligible for Medicaid as a result of the Title XXI Medicaid expansion were developed using the following procedures. First, the growth adjustment factors released by the U.S. Census Bureau were applied to 1990 CPS data on Indiana's population by year of age to derive 1999

estimates of Indiana's population by year of age. Second, the 1996 and 1997 CPS poverty rates for children less than 19 years of age were applied to the 1999 population estimates to determine the number of children at or below various poverty levels, including 100%, 150% and 200% of the federal poverty level. Finally, the uninsured rates calculated from the 1996 CPS by the Employee Benefit Research Institute were applied to the 1999 estimates of the number of children at or below various poverty levels.

1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

The baseline estimates were derived from CPS data. The CPS sample size in Indiana is quite small and therefore is unlikely to provide an accurate reflection of Indiana's uninsured population. The three-year average of the 1996, 1997, and 1998 CPS data suggests that there are 123,000 uninsured children in Indiana below 200% of the federal poverty level. However, the standard error of this value is 26,900 with a 95% confidence interval ranging from 70,276 to 175,724. Indiana's Medicaid enrollment since the Title XXI expansion to 150 percent of the federal poverty level began July 1, 1998 has already exceeded the estimated number of uninsured children who were eligible for Medicaid.

Thus, the State of Indiana will conduct a statewide survey of the uninsured to obtain a more accurate baseline estimate of uninsured low-income children and families. Data from the survey will become available in May or June 2000.

1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

There were 316,044 children enrolled in Hoosier Healthwise, Indiana's Medicaid managed care program, as of September 30, 1999. Title XXI outreach efforts across the State had increased enrollment in the Hoosier Healthwise program by 105,571 children when compared to Hoosier Healthwise enrollment figures for May 1998. This enrollment increase includes children enrolled in Title XIX Medicaid, children enrolled in Title XXI Medicaid as a result of the Medicaid expansion in 1997 to children born before October 1, 1983, with family incomes of no more than 100 percent of the federal poverty level, and children enrolled in Title XXI Medicaid due to the July 1998 expansion to 150 percent of the federal poverty level.

As indicated in our quarterly enrollment and expenditure data, the number of children ever enrolled at some point during the year in Indiana's Title XXI program was 25,194 for Federal Fiscal Year 1998, and 34,902 for Federal Fiscal Year 1999. These enrollment figures include children enrolled in Title XXI Medicaid as a result of the 1997 expansion and the 1998 expansion.

1.2.1 What are the data source(s) and methodology used to make this estimate?

Hoosier Healthwise enrollment figures are based on unduplicated, point-in-time counts on the last day of each month from Indiana's Client Eligibility System (ICES).

Title XXI enrollment figures are based on unduplicated, point-in-time counts on the last day of each month according to IndianaAIM, Indiana's Medicaid Management Information System.

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

We may be underestimating the number of children enrolled in Title XXI because they are based on point-in-time data. Specifically, at a certain point each month the IndianaAIM system identifies children enrolled in Medicaid who satisfy the age, income, and insurance status eligibility requirements for Title XXI. The data may not represent 1) children whose health insurance status changed so that they were eligible for Title XXI on at least one day of the month but not on the day that the data were captured, or 2) children who were retroactively eligible for the program. The average child is granted approximately 62 days of retroactive coverage when he or she is enrolled in the program. Consequently, a retroactive review of CHIP enrollment activity for FFY 1998 and FFY 1999 suggests that the quarterly enrollment counts represent approximately 38 to 55 percent of the newly enrolled children who will actually receive health coverage during that period. We may be underreporting the number of newly enrolled children in Title XXI by as much as 45 to 62 percent.

Our confidence in the Hoosier Healthwise enrollment figures is much higher because the data are captured at the same time every month and children are only ever enrolled or disenrolled through ICES on the first day of the month. Thus, every child enrolled during a month is captured by the point-in-time count conducted at the end of each month.

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List the State's strategic objectives for the CHIP program, as specified in the State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Uninsured, targeted low-income children will have health insurance as a result of Indiana's Title XXI program.	The CPS conducted in 1999 will show a 10% reduction in the percentage of targeted low-income children who do not have health insurance coverage over the findings of the 1998 results.	Data Sources: Current Population Survey (CPS) Methodology: Comparison of the reported average of 1995, 1996, and 1997 CPS data with the reported average of 1996, 1997, and 1998 CPS data Numerator: Number of children under 200% FPL who are uninsured according to reported average of 1995, 1996, and 1997 CPS data Denominator: Progress in reducing the number of children under 200% FPL who are uninsured according to reported average of 1996, 1997, and 1998 CPS data Progress Summary: The reported average of 1996, 1997, and 1998 CPS data suggested a 1.3% reduction in the percentage of targeted low-income children who do not have health insurance coverage over the reported average of the 1995, 1996, and 1997 results.

OBJECTIVES RELATED TO CHIP ENROLLMENT		
Uninsured, targeted low-income children will have health insurance through Indiana's Title XXI program.	By September 30, 1999, 40,000 previously uninsured, targeted low-income children will have health insurance through Title XXI.	Data Sources: IndianaAIM (Medicaid Management Information System) Methodology: Based on combined unduplicated count for October 1, 1997 through September 30, 1999 Numerator: NA Denominator: NA Progress Summary: There were 61,976 children who obtained health insurance through Indiana's Title XXI program at some point between October 1, 1997 and September 30, 1999.

OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
Children currently eligible but not enrolled in Medicaid will be identified and enrolled in that program.	By September 30, 1999, there will be at least a 10% increase in Title XIX Medicaid enrollment of children under age 19.	Data Sources: Indiana Client Eligibility System (ICES) Methodology: Based on unduplicated, point-in-time counts of Hoosier Healthwise Title XIX eligibility categories as of May 31, 1998 and September 30, 1999 Numerator: Number of children enrolled in Hoosier Healthwise Title XIX eligibility categories as of May 31, 1998 Denominator: Progress in increasing the number of children enrolled in Hoosier Healthwise Title XIX eligibility categories as of September 30, 1999 Progress Summary: As of September 30, 1999, Title XIX Medicaid enrollment of children under age 19 had increased by 38.9 percent since May 31, 1998.

OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
Children enrolled in Indiana's Title XXI program will have a consistent source of medical and dental care.	By September 30, 1999, 95% of children enrolled in Title XXI will self-select their primary medical provider.	Data Sources: IndianaAIM (Medicaid Management Information System) Methodology: Comparison of Hoosier Healthwise primary medical provider (PMP) auto-assignment rates for June 1998 and September 1999 Numerator: Hoosier Healthwise PMP auto-assignment rate for June 1998 Denominator: Progress in decreasing the Hoosier Healthwise PMP auto-assignment rate as of September 1999 Progress Summary: In June 1998, 15 percent of Hoosier Healthwise members were auto-assigned to a PMP. In comparison, of the 22,995 members who enrolled in Hoosier Healthwise in September 1999, only 1,879 (8%) were auto-assigned to a PMP in September 1999. Thus, 92 percent of members self-selected their PMPs in September 1999. These figures include children enrolled in Title XIX Medicaid, as well as Title XXI Medicaid. Unfortunately, at this time, we are unable to obtain Title XXI-specific auto-assignment data.

OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
Children enrolled in Hoosier Healthwise will enjoy improved health status.	By September 30, 1999, measures of health status in place for Hoosier Healthwise will show improvements in the immunization of 2-year olds, and preventive health services.	Data Sources: Hoosier Healthwise Childhood Immunization Year One Focus Study (see Attachment C) Methodology: Reviewed medical records maintained by the primary medical provider (PMP) of a random sample of children enrolled in Hoosier Healthwise who had their second birthday between October 1, 1995 and September 30, 1996 and were continuously enrolled for six months prior to their second birthday. Numerator: NA Denominator: NA Progress Summary: Approximately 49% of the children studied had received the full complement of immunizations recommended by the American Academy of Pediatrics (4 doses of diphtheria, tetanus, and pertussis; 3 doses of polio virus; 1 dose of measles, mumps, rubella; 3 doses of hemophilus influenza type B; and 3 doses of Hepatitis B vaccines). Less than 21% of the children studied had visited their PMP within the last six months. Unfortunately, data are not available at this time to determine whether or not the immunization and well-child care rates have improved since implementation of the Title XXI Medicaid expansion.

OTHER OBJECTIVES		
Parents/children enrolled in Title XXI will be satisfied with the program.	At least 75% of parents surveyed during the first year of their child's participation will express overall satisfaction with the Title XXI program.	Data Sources: 1998 Hoosier Healthwise Member Satisfaction Survey (see Attachment D) Methodology: The survey was a random sample of 1,505 Hoosier Healthwise members from throughout Indiana enrolled in September 1998 and who had been in the program greater than six months. The survey was conducted in either a one-on-one telephone or in-person interview in which each question was read exactly as worded. Responses were recorded and sent to an independent market research organization for data analysis. The survey used two questionnaires; one for the adult population and one for the child population. Numerator: NA Denominator: NA Progress Summary: Over three-quarters (86%) of the members surveyed rated the Hoosier Healthwise program as very good or good (using a five point scale). This figure includes children enrolled in Title XIX Medicaid as well as children enrolled in Title XXI. Unfortunately, at this time, we are unable to obtain Title XXI-specific member satisfaction data.

Providers who participate in the Title XXI program will express satisfaction with the terms and conditions of their participation.	At least 50% of providers surveyed will express overall satisfaction with the Title XXI program.	Data Sources: 1998 Hoosier Healthwise Primary Medical Provider Satisfaction Survey (see Attachment E) Methodology: A total of 1,888 questionnaires were distributed to Hoosier Healthwise primary medical providers (PMPs) to be completed by PMPs, office managers and other office staff. There was a 42% response rate with 792 completed questionnaires being returned to an independent market research organization for data analysis. Numerator: NA Denominator: NA Progress Summary: The study revealed that 58% of PMPs were at least somewhat satisfied with the Hoosier Healthwise program. PMP satisfaction with the Hoosier Healthwise program had increased from 53% in 1997, prior to implementation of the Title XXI Medicaid expansion.

The child health programs and payment sources in Indiana will be coordinated to achieve family-friendly, seamless systems of care.	The Hoosier Healthwise toll-free Helpline will track system responsiveness and priority issues for parents.	Data Sources: Hoosier Healthwise Helpline Monthly Statistics for January through September 1999 Methodology: The number of calls received by the Helpline, the average length per call, the average wait time for calls, and the reasons for the calls were tracked by the Hoosier Healthwise Helpline staff. Numerator: NA Denominator: NA Progress Summary: The Hoosier Healthwise Helpline received an average of 3,358 calls per month from January through September 1999 pertaining to Hoosier Healthwise for Children. The average length per call was one minute, forty seconds, and the average wait time for answered calls was one or two seconds. The three most frequent reasons for the calls were eligibility for the program, the annual eligibility redetermination process, and PMP auto-assignment.

Objective 1: Uninsured, targeted low-income children will have health insurance as a result of Indiana's Title XXI program.

Although the performance goal for this objective was a 10% reduction in the percentage of uninsured, targeted low-income children in Indiana, the reported average of 1996, 1997, and 1998 CPS data suggested a 1.3% reduction. However, CPS data, in all likelihood, do not present an accurate estimate for Indiana. The CPS sample size in Indiana is quite small and therefore is unlikely to provide an accurate reflection of Indiana's uninsured population. The three-year average of the 1996, 1997, and 1998 CPS data suggests that there are 123,000 uninsured children in Indiana below 200% of the federal poverty level. However, the standard error of this value is 26,900 with a 95% confidence interval ranging from 70,276 to 175,724. Medicaid enrollment since the Title XXI expansion began July 1, 1998 has already exceeded the baseline

estimates derived from CPS data of the number of children who were eligible but unenrolled in Medicaid. Thus, the State of Indiana will conduct a statewide survey of the uninsured to obtain a more accurate baseline estimate of uninsured low-income children and families. Data from the survey will become available in May or June 2000.

Objective 2: Uninsured, targeted low-income children will have health insurance through Indiana's Title XXI program.

Indiana exceeded the Title XXI enrollment goal of 40,000 previously uninsured, targeted low-income children, by approximately 55 percent. There were 61,976 children who received health insurance through Indiana's Title XXI program at some point during Federal Fiscal Year 1998 or Federal Fiscal Year 1999. This figure includes children who became eligible for Hoosier Healthwise as a result of the 1997 Medicaid expansion to children born before October 1, 1983, with family incomes of no more than 100 percent of the federal poverty level, and children who became eligible for Hoosier Healthwise due to the 1998 expansion to 150 percent of the federal poverty level.

The unduplicated enrollment counts reported in the HCFA fourth quarter reports for Federal Fiscal Year 1998 (25,194) and Federal Fiscal Year 1999 (34,902) are lower than the actual number of children who received health insurance through Indiana's Title XXI program between October 1, 1997, and September 30, 1999, because of federal reporting requirements. The HCFA quarterly enrollment reports reflect the last program in which a child was enrolled. Thus, if a child was enrolled in CHIP at the beginning of the year, but was enrolled in Medicaid at the end of the federal fiscal year, to avoid duplication, the child will only be included in the Medicaid count of the unduplicated number of children ever enrolled in the year. The unduplicated number of children who received services at some point during Federal Fiscal Year 1998 or Federal Fiscal Year 1999 was actually 61,976.

The success of the program may be attributed to the efforts undertaken by the State to re-engineer the application process to make it easier for families to apply and participate, de-stigmatize Medicaid, encourage community participation and collaboration, and implement aggressive promotion strategies (see Attachment B).

Indiana will further expand these outreach efforts to ensure that all uninsured, targeted low-income children are enrolled, including those children who are eligible for the second Hoosier Healthwise expansion, which is a state-designed program. This second phase of CHIP began January 1, 2000 to provide coverage to children under age 19 in families with incomes between 150 and 200 percent of the federal poverty level. Indiana is contracting for a social marketing initiative that will better define the eligible populations and design and implement a targeted

marketing campaign.

Objective 3: Children currently eligible but not enrolled in Medicaid will be identified and enrolled in that program.

The State of Indiana exceeded the goal to increase Title XIX Medicaid enrollment of children under age 19 by at least 10 percent. As of September 30, 1999, Title XIX Medicaid enrollment of children under age 19 had increased by 38.9 percent since May 31, 1998. These enrollment successes may be attributed to the State's outreach efforts (see Attachment B). A survey is being conducted to obtain a more accurate estimate of the remaining number of children who may be eligible for Title XIX Medicaid but not enrolled.

Objectives 4: Children enrolled in Indiana's Title XXI program will have a consistent source of medical and dental care.

All children enrolled in Hoosier Healthwise select or are assigned to a primary medical provider (PMP) unless the child is a ward of the State, resides in an institution, requires a certain level of care, or lives in a medically underserved area that does not have a provider available to serve as the child's PMP. In June 1998, prior to the 1998 Title XXI Medicaid expansion, 15 percent of Hoosier Healthwise members were auto-assigned to a PMP. In comparison, only 8 percent of Hoosier Healthwise members were auto-assigned to a PMP in September 1999. Although the State did not achieve the goal of 95 percent PMP self-selection by September 30, 1999, the auto-assignment rate continues to decrease. These figures include children enrolled in Title XIX Medicaid as well as Title XXI Medicaid. Unfortunately, at this time, we are unable to obtain Title XXI-specific auto-assignment data.

Between June 1998, and September 1999, 109 PMPs and 258 new dentists joined the program, for a total of 1,941 PMPs and 1,608 dentists. In May 1998, there were PMPs in only 88 of the 92 counties. As of September 1999, there were PMPs in all 92 counties. Targeted recruitment efforts are currently being focused on several counties where the State wants to increase the numbers of PMPs serving the county. For these counties, new enrollees may either remain in the fee for service program whereby they can access any Medicaid enrolled physician, or choose PMPs in contiguous counties.

Objectives 5: Children enrolled in Hoosier Healthwise will enjoy improved health status.

The Hoosier Healthwise Childhood Immunization Year One Focus Study revealed that immunization rates for children enrolled in Hoosier Healthwise did not meet the *Healthy People 2000* objectives (see Attachment B). Several factors that may have contributed to the rates being below the goal have since been identified. Inconsistent charting and poor documentation of immunizations given, or immunization records received from other physicians, made it difficult in many instances to verify that one or more immunizations had been given. Also, the number of children with up-to-date immunizations may be greater than counted because out-of-plan immunizations were not always captured in the PMP's medical records. Strategies are being designed to address these issues and improve levels of immunization in the future.

Historically the immunization rates for Hoosier Healthwise obtained through focus studies have been lower than other data sources would suggest. For example, the 1998 Assessment of Indiana's Public Health Clinic Immunization Coverage Levels Report, prepared by the Indiana State Department of Health, revealed that approximately 68 percent of children who were active patients of local health departments and approximately 60 percent of patients of non-health department public clinics had received the 4:3:1:3:3 vaccination series.

We were unable to satisfy our performance goal for this objective because focus studies that examine more recent Hoosier Healthwise preventive care information have yet to be completed. Focus studies will eventually be conducted for children who have enrolled in Hoosier Healthwise since the Title XXI Medicaid expansion.

Objective 6: Parents/children enrolled in Title XXI will be satisfied with the program.

The 1998 Hoosier Healthwise Member Satisfaction Survey (Attachment D) revealed that the performance goal for this objective was exceeded during the first year of the Title XXI Medicaid expansion, with over three-quarters (86%) of the members surveyed rating the Hoosier Healthwise program as very good or good (using a five point scale). This figure includes children enrolled in Title XIX Medicaid as well as children enrolled in Title XXI. Unfortunately, at this time, we are unable to obtain Title XXI-specific member satisfaction data.

Objective 7: Providers who participate in the Title XXI program will express satisfaction with the terms and conditions of their participation.

The 1998 Hoosier Healthwise Primary Medical Provider Satisfaction Survey demonstrated that PMP satisfaction with the Hoosier Healthwise program continued to increase when compared with previous years despite implementation of the Title XXI Medicaid expansion (see

Attachment E). Nevertheless, approximately 34% of PMPs continued to be at least somewhat dissatisfied with the program. The majority of PMPs expressed dissatisfaction with the auto-assignment process, patient compliance with the program, patients keeping appointments, and patient compliance with their PMPs. All of the issues that were identified through the survey process as sources of dissatisfaction are being examined, and options are being considered in an effort to continue to increase provider satisfaction with the Hoosier Healthwise program.

Objective 8: The child health programs and payment sources in Indiana will be coordinated to achieve family-friendly, seamless systems of care.

Beginning August 1, 1998, the Hoosier Healthwise application form was simplified to a double-sided single sheet, a mail-in application was made available, and the documentation required to verify eligibility for the program was reduced. Families can now apply for Hoosier Healthwise through a mail-in application, at one of 120 Division of Family and Children local offices, or at one of almost 500 enrollment centers throughout the State, such as clinics, schools and child care centers. The Family and Social Services Administration, the State agency responsible for Hoosier Healthwise, is also working closely with other agencies and agency programs to ensure that all families are educated about the Hoosier Healthwise program (see Attachment B).

The Hoosier Healthwise Helpline received an average of 3,358 calls per month from January through September 1999 pertaining to Hoosier Healthwise for Children. The average length per call was one minute, forty seconds, and the average wait time for answered calls was one or two seconds. The three most frequent reasons for the calls were eligibility for the program, the annual eligibility redetermination process, and PMP auto-assignment. The Helpline will continue to monitor the calls that it receives to ensure that the responsiveness of the system is maintained and indicate whether the reasons for the calls are affected by the January 1, 2000 Hoosier Healthwise expansion.

SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

X Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: Hoosier Healthwise

Date enrollment began (i.e., when children first became eligible to receive services):

Enrollment for the Medicaid expansion to 100 percent of the federal poverty level for children born before October, 1, 1983, began June 1, 1997.

Enrollment for the Medicaid expansion to 150 percent of the federal poverty level began in June 1998 and children became eligible to receive services July 1, 1998.

___ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Family Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Employer-sponsored Insurance Coverage

Name of program: _____

_____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Wraparound Benefit Package

Name of program: _____

_____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other (specify)

Name of program:

_____

Date enrollment began (i.e., when children first became eligible to receive services):

2.1.2 **If State offers family coverage:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

2.1.3 **If State has a buy-in program for employer-sponsored insurance:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

2.2 What environmental factors in your State affect your CHIP program? (Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

Employment is a significant source of health insurance for most Indiana residents. Indiana, as compared to other states, has a high rate of employer-sponsored and individual health care coverage for children—as high as 91 percent, by some estimates. This high rate of coverage represents a strength of Indiana's health care system and was an important consideration for CHIP policymakers. The possible erosion or "crowd-out" of privately-provided insurance due to the availability of a new publicly-sponsored program was taken into account in the design of CHIP policies regarding eligibility determination, the benefit package, and any cost-sharing requirements.

Prior to CHIP there were 33 public programs serving children in Indiana. The primary public health insurance available in Indiana is through the Medicaid program. Hoosier Healthwise, a mandatory managed care program under Medicaid, has been phased-in. Hoosier Healthwise is comprised of a Primary Care Case Management system and a Risk-Based Managed Care (RBMC) system. Under both of these systems, primary medical providers (PMPs) provide preventive and primary medical care, and furnish authorizations and referrals for most specialty services. Children eligible for Hoosier Healthwise through the Title XXI expansion have been integrated into these managed care networks.

In order to maximize the strengths of the existing system and the economies of scale, the State decided to implement a Medicaid expansion as the first phase of Indiana's CHIP program to:

- avoid confusion among providers and recipients;
- minimize costs;
- provide continuity of care for children who move between the Title XIX and Title XXI programs;
- leverage change in Medicaid to de-stigmatize participation in the program;
- ensure that the program did not evolve into a two-tiered system under which children enrolled in Hoosier Healthwise would be perceived as receiving a lower standard of service than children enrolled in a separate state program;
- provide a safety net for the most financially vulnerable population;
- eliminate the prospect of disrupting both services to children currently in Medicaid and progress in increasing those enrollments;
- provide an opportunity to expand health care coverage to the greatest number of currently uninsured children; and
- limit eligibility for the entitlement program to children in families earning up to 150 percent of the federal poverty level, thereby decreasing the likelihood of crowd-out.

Prior to July 1, 1998, eligibility for Indiana's Medicaid program among pregnant women and children was based on income and the age of the child. Pregnant women and infants under 1 year of age were eligible if the family income was 150 percent of the federal poverty level or

less. Children between the ages of 1 and 6 years were eligible if the family income was 133 percent of the federal poverty level or less. Children from ages 6 years through 18 were eligible if family income did not exceed 100 percent of the federal poverty level. Until June 1997, children ages 13 through 18 were eligible for Medicaid if family income did not exceed 26 percent of the federal poverty level. Thus, a family may have had one or more children eligible for Medicaid while other children in the family remained ineligible, due to the children's ages and the family's income. This "stair-step" arrangement presented a barrier to enrollment because it contributed to confusion among families and appeared to arbitrarily exclude children from the program. The Medicaid expansion to 150 percent of the federal poverty level is a key element to outreach and streamlined enrollment efforts, and its enactment eliminated a major barrier for families.

2.2.2 Were any of the preexisting programs "State-only" and if so what has happened to that program?

X No pre-existing programs were "State-only"

___ One or more pre-existing programs were "State only" Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

X Changes to the Medicaid program

___ Presumptive eligibility for children
___ Coverage of Supplemental Security Income (SSI) children
X Provision of continuous coverage (specify number of months 12)
___Elimination of assets tests

Assets tests for Hoosier Healthwise were eliminated prior to the Title XXI Medicaid expansion.

X Elimination of face-to-face eligibility interviews

Individuals may apply for Hoosier Healthwise by mail, or at one of almost 500 enrollment centers or 120 Division of Family and Children (DFC) offices located throughout the State. English and Spanish versions of the mail-in application may be obtained by calling the toll-free Hoosier Healthwise Helpline or may be downloaded from the internet. Individuals who apply by mail are required to participate in a telephone interview.

X Easing of documentation requirements

The State has developed a simplified one page, double-sided Hoosier Healthwise application form. Applicants may self-declare their date of birth, citizenship, and child care expenses. Documentation is required to verify income and immigration status.

X Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify)

As of September 1999, Medicaid enrollment of children, pregnant women and low income families was higher than in July 1995 when welfare reform began in Indiana.

___ Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

- ___ Health insurance premium rate increases
- ___ Legal or regulatory changes related to insurance
- ___ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
- ___ Changes in employee cost-sharing for insurance
- ___ Availability of subsidies for adult coverage
- ___ Other (specify) _____ _____ _____

___ Changes in the delivery system

- ___ Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)
- ___ Changes in hospital marketplace (e.g., closure, conversion, merger)

___ Other (specify) _____ _____ _____

___ Development of new health care programs or services for targeted low-income children (specify) _____

X Changes in the demographic or socioeconomic context

X Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify)

As of September 1999, there had been a slight change in the racial/ethnic composition of children enrolled in Medicaid since July 1998. There was a 1.7 percent increase in the proportion of white children enrolled, a 0.7 percent increase in the proportion of Hispanic children enrolled, and a 2.4 percent decrease in the proportion of black or African American children enrolled. Yet, white children continued to constitute the majority of children enrolled in Medicaid at 65.3 percent, 28 percent of children enrolled were black, and Hispanic children accounted for 5.5 percent of children enrolled in Medicaid as of September 1999.

X Changes in economic circumstances, such as unemployment rate (specify)

According to the U.S. Department of Labor, Bureau of Labor Statistics, "Local Area Unemployment Statistics", the unemployment rate in Indiana decreased by 0.1 percent from November 1998 to November 1999.

___ Other (specify) _____ _____ _____

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

Table 3.1.1 (Also see Attachment A – Addendum to Table 3.1.1)

	Medicaid CHIP Expansion Program	**State-designed CHIP Program**	**Other CHIP Program*** _____
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	Statewide		
Age	1-18 years		
Income (gross monthly income of family less $90)	0-150% FPL		
Resources (including any standards relating to spend downs and disposition of resources)	NA		
Residency requirements	Must be State resident		
Disability status	NA		
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	NA		

Other standards (identify and describe)	Must be U.S. citizen or qualified immigrant as defined by the Personal Responsibility and Work Opportunity Reconciliation Act.		

**Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".*

3.1.2 How often is eligibility redetermined?

Table 3.1.2			
Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Monthly			
Every six months			
Every twelve months	X		
Other (specify)_____			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

X Yes ° Which program(s)? Medicaid Expansion_____

For how long? 12 months_____

___ No

3.1.4 Does the CHIP program provide retroactive eligibility?

X Yes ° Which program(s)? Medicaid Expansion_____

How many months look-back? Up to 3 months_____

___ No

3.1.5 Does the CHIP program have presumptive eligibility?

___ Yes ° Which program(s)? _____

Which populations?_____

Who determines?_____

X No

3.1.6 Do your Medicaid program and CHIP program have a joint application?

X Yes ° Is the joint application used to determine eligibility for other State programs? If yes, specify. _

The Hoosier Healthwise joint application used for both the Medicaid and CHIP programs is not used by other State programs. However, Hoosier Healthwise has been included on a combined application form used by the Maternal and Child Health program (Title V), Indiana's program for Children's Special Health Care Services (Title V), and Indiana's First Steps program (Part C, IDEA).

___ No

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children

The Hoosier Healthwise application process has been streamlined and simplified to make it easier and more convenient for families to apply and participate. Individuals may apply for Hoosier Healthwise by mail, or at one of almost 500 enrollment centers or 120 Division of Family and Children (DFC) offices located throughout the State.

The State has also developed a simplified one page, double-sided Hoosier Healthwise application form. There are no assets tests, and applicants may self-declare their date of birth, citizenship, and child care expenses. Documentation is required to verify income and immigration status.

One of the weaknesses of the eligibility determination process is the length of time required to process the applications. The statewide average time for authorizing an application was 40.2 days in August 1999, and the median was 36 days. Approximately 10 percent of the applications were processed within 10 days, almost 18 percent were processed between 11 and 20 days from the application date, the processing time for more than 15 percent of applications was 21 to 30 days, and more than 56 percent of applications took more than 30 days to be processed.

3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

Unlike the eligibility determination process, the Hoosier Healthwise eligibility redetermination process does not require an application form and is not conducted by enrollment center representatives.

Families are notified by computer generated notice of the need to schedule an appointment to re-establish eligibility. The interview can be conducted by phone or in person. Caseworkers are encouraged to be as flexible as possible to work with the family to schedule an interview which will not interfere with parent's work schedule or other obligations.

In some counties, if a caseworker is unable to locate a family to complete the redetermination process, the family's enrollment information is sent back to the enrollment center where the original application was received so that the enrollment center may attempt to contact the family.

One of the weaknesses of the eligibility redetermination process is that the Local Division of Family and Children offices, for the most part, continue to operate during the hours of 8:00AM to 5:00PM. This schedule is not optimal for parents who are working. However, in June 1999 the Division of Family and Children instituted new guidelines requiring the distribution of reminder notices and introducing a mail-in eligibility redetermination form. Also, several local offices have recently extended their office hours into the evening or on weekends. Over the next year, this practice will become more common.

3.2 What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

Table 3.2.1 CHIP Program Type Medicaid Expansion			
Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	T		
Emergency hospital services	T		
Outpatient hospital services	T		
Physician services	T		Prior authorization required for more than 30 PMP visits in a twelve-month period
Clinic services	T		
Prescription drugs	T		
Over-the-counter medications	T		
Outpatient laboratory and radiology services	T		
Prenatal care	T		
Family planning services	T		
Inpatient mental health services	T		
Outpatient mental health services	T		
Inpatient substance abuse treatment services	T		
Residential substance abuse treatment services	T		
Outpatient substance abuse treatment services	T		
Durable medical equipment	T		
Disposable medical supplies	T		

Preventive dental services	T		
Restorative dental services	T		
Hearing screening	T		
Hearing aids	T		
Vision screening	T		Initial vision care examination limited to one examination per year unless more frequent care is medically necessary
Corrective lenses (including eyeglasses)	T		Eyeglasses, including frames and lenses, limited to a maximum of one pair per year except when a specified minimum prescription change makes additional coverage medically necessary or the lenses and/or frames are lost, stolen, or broken beyond repair
Developmental assessment	T		
Immunizations	T		
Well-baby visits	T		
Well-child visits	T		
Physical therapy	T		
Speech therapy	T		
Occupational therapy	T		
Physical rehabilitation services	T		
Podiatric services	T		Routine foot care visits limited to six per year
Chiropractic services	T		Limited to five visits and 50 therapeutic physical medicine treatments per member per year
Medical transportation	T		

Home health services	T		
Nursing facility	T		
ICF/MR	T		
Hospice care	T		
Private duty nursing	T		
Personal care services			
Habilitative services			
Case management/Care coordination	T		
Non-emergency transportation	T		Non-emergency travel available for up to 20 one-way trips of less than 50 miles per year without prior authorization
Interpreter services	T		Medicaid providers are required to make interpreter services available to members. Reimbursement for these services is not direct, but is included in the capitation payments.
Other (Specify)_____			
Other (Specify)_____			
Other (Specify)_____			

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

The scope and range of health benefits provided by the Title XXI Medicaid expansion program are the same as those available under the Title XIX Medicaid program, and are defined by Health Watch. Health Watch refers to the Early and Periodic Screening Diagnosis and Treatment (EPSDT) available to Medicaid recipients under the age of 21. Through Health Watch screenings, all Medicaid –provided services are available to children, as well as any other services that are deemed medically necessary for the health of the child. The broad definition of medical necessity utilized in Indiana ensures that children enrolled in the program have access to recommended or required preventive, acute, and long-term care services. When a benefit limitation has been exhausted, the service may still be covered if prior authorization based on medical necessity is obtained.

These fundamental health services are complemented by generous enabling services. Non-emergency transportation is available for families who need assistance getting to and from medical appointments, Medicaid providers are required to make appropriate interpretation services available to Medicaid patients, outreach and member materials are provided in both English and Spanish, and the toll-free helplines have established procedures to provide assistance to current or potential members in a number of languages.

Children who may require health services beyond those included in the Medicaid benefit package are also likely to qualify for Indiana's First Steps program or Indiana's Title V program for children with special health care needs. Both programs provide supplementary services to children enrolled in Medicaid, such as planning and service coordination, support services, and information and communication.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Table 3.2.3			
Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____ _____
A. Comprehensive risk managed care organizations (MCOs)	X		
Statewide?	X Yes ___ No	___ Yes ___ No	___ Yes ___ No
Mandatory enrollment?	X Yes ___ No	___ Yes ___ No	___ Yes ___ No
Number of MCOs	2		
B. Primary care case management (PCCM) program	X		
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)			
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	Mental health services and dental services (except when provided in an acute care setting) are carved out of risk-based managed care to fee-for-service.		
E. Other (specify)_____			
F. Other (specify)_____			
G. Other (specify)_____			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/ copayments, or other out-of-pocket expenses paid by the family.)

X No, skip to section 3.4

___ Yes, check all that apply in Table 3.3.1

Table 3.3.1

Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*_____ _____
Premiums			
Enrollment fee			
Deductibles			
Coinsurance/copayments**			
Other (specify) _____			

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

**See Table 3.2.1 for detailed information.

3.3.2 **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

___ Employer
___ Family
___ Absent parent
___ Private donations/sponsorship
___ Other (specify) _____

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

___ Shoebox method (families save records documenting cumulative level of cost sharing)
___ Health plan administration (health plans track cumulative level of cost sharing)
___ Audit and reconciliation (State performs audit of utilization and cost sharing)
___ Other (specify) _____

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used

(**T**=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.1						
Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program _____ _____ _____ _	
	T = Yes	Rating* (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Billboards	T	3				
Brochures/flyers	T	3				
Direct mail by State/enrollment broker/administrative contractor	T	3				
Education sessions	T	3				
Home visits by State/enrollment broker/administrative contractor	T	5				
Hotline	T	5				
Incentives for education/outreach staff						
Incentives for enrollees	T	3				
Incentives for insurance agents						
Non-traditional hours for application intake	T	4				
Prime-time TV advertisements	T	4				
Public access cable TV	T	4				

Developed by the National Academy for State Health Policy

Public transportation ads	T	1				
Radio/newspaper/TV advertisement and PSAs	T	4				
Signs/posters	T	2				
State/broker initiated phone calls						
Other (specify) Give-aways to promote Hoosier Healthwise and the toll-free helpline such as T-shirts, frisbees, rulers, pencils, sippy cups, insulated snack bags, and snack containers	T	3				
Other (specify) County-specific outreach plans (see Attachment B)	T	5				
Other (specify) Enrollment Centers	T	5				
Other (specify) Internet	T	2				
Other (specify) Word of Mouth	T	5				

*Client education and outreach approaches were rated according to innovation, the number of inquiries generated, or the number of counties in which the approaches are being used.

3.4.2 Where does your CHIP program conduct client education and outreach?

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (**T**=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.2						
Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Battered women shelters	T	3				
Community sponsored events	T	3				
Beneficiary's home	T	5				
Day care centers	T	3				
Faith communities	T	3				
Fast food restaurants	T	3				
Grocery stores	T	3				
Homeless shelters	T	3				
Job training centers	T	4				
Laundromats	T	3				
Libraries						
Local/community health centers	T	5				
Point of service/provider locations	T	5				
Public meetings/health fairs	T	4				

Public housing	T	3				
Refugee resettlement programs	T	3				
Schools/adult education sites	T	5				
Senior centers						
Social service agency	T	3				
Workplace	T	3				
Other (specify) Head Start	T	2				
Other (specify) Department of Workforce Development	T	4				
Other (specify) Healthy Families	T	4				

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

The effectiveness of the State's outreach efforts is measured in accordance with the number of children who have enrolled. The outreach initiative resulted in a Hoosier Healthwise enrollment increase of more than 105,000 children. This increase is the clearest evidence that the outreach succeeded in bringing more eligible children into Hoosier Healthwise. The success of the effort is based upon the following basic principles:

- executive commitment;
- legislative support;
- clear policy expectations;
- local implementation strategies;
- respect for users of the service; and
- commitment to seamless, coordinated systems for members and providers.

When the 1998 Title XXI Medicaid expansion began, Governor O'Bannon directed the State to implement a comprehensive outreach campaign targeting 91,000 uninsured children eligible for Hoosier Healthwise. Local Offices of Family and Children in Indiana's 92 counties were charged with developing community-level partnerships with other service providers and public, non-profit and private organizations. The Local Office directors are responsible for working with these and other potential partners in the individual communities, and for establishing enrollment centers that meet the needs of the individual communities and the particular partners. Each county was also given a county-specific enrollment target (see Attachment F).

The State is also piloting enrollment strategies in eight communities on a three-year Robert Wood Johnson (RWJ) Covering Kids outreach grant which targets hard to reach populations. Eight local coalitions are implementing innovations to identify and enroll the hardest to serve populations. The coalitions represent over 150 local partners, including companies, schools, health organizations, service providers and parents. The three-year project will allow for pilot testing of new strategies, including electronic applications completed in clients' homes, partnering with schools, and enrollment in various offices that serve eligible families.

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

Recognizing the importance of having culturally sensitive and culturally specific outreach strategies, the State contracted with three statewide organizations (Indiana Minority Health Coalition, Indiana Black Expo, and the Wishard Hispanic Health Project) to target minority populations across the State. These organizations have worked closely with the Local Offices of Family and Children, other community organizations and each other to develop culturally specific materials and specifically target African American, Latino and Native American families (see Attachment B).

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

The advent of the Children's Health Insurance Program provided the State with an opportunity to revisit issues of Medicaid access and outreach at the same time as significant policy changes were being implemented in the wake of welfare reform. Since the outreach campaign began in July 1998, increases in enrollment of children who were traditionally eligible for Medicaid but not enrolled and of children who became eligible as a result of the expansion have been phenomenal. Indeed, as of September 1999, the enrollment of children in Hoosier Healthwise had increased more than 50 percent since May 1998. These enrollment increases may be attributed to the implementation of policy changes, the formation of new statewide and local partnerships with healthcare-related organizations, and the commitment of State employees to the enrollment of all eligible children.

From the beginning, the State recognized that local enrollment strategies would be fundamental to the success of the outreach campaign. Consequently, outreach funding was distributed to each of the 92 local Division of Family and Children (DFC) offices to develop a community-based outreach plan. Each DFC director was given a Hoosier Healthwise enrollment target, required to submit an enrollment plan, and provided funding to support the plan. The most common strategies employed by the local DFC offices have been 1) staff attendance as local fairs and special events, where they have been distributing brochures and marketing materials, and talking to families about the program; 2) media campaigns that have included billboard, newspaper, radio and television advertising; 3) establishing partnerships with local school corporations to distribute Hoosier Healthwise materials to parents; and 4) providing Hoosier Healthwise information to physicians to be made available in their offices.

There are some families who may not wish to enroll for Medicaid due to the stigma of going to a local DFC office to enroll. Thus, mail-in applications were introduced and, since July 1998, almost 500 enrollment centers have been established throughout the State. The enrollment centers are diverse and include community action centers, child care centers, health centers and hospitals, schools and various service providers. As of September 1999, almost 20,000 applications have been processed through the enrollment centers. Hospitals and health centers have been especially active in enrollment (see Attachment F). Local DFC offices have commented that concerns about stigma that they encountered prior to the outreach campaign have become less evident over time.

To ensure that minority populations were reached, grants were awarded to three minority community partners to develop specific strategies for underserved populations: the Indiana Minority Health Coalition, Inc., Indiana Black Expo, Inc., and Wishard Health Services' Hispanic Health Project. These organizations have engaged in statewide outreach activities targeting specific minority populations, including the translation and distribution of marketing materials and applications, the coordination of the outreach activities of community organizations, and the organization of media coverage.

Local faith communities are often a trusted source of information for underserved communities. Many local DFC offices and community partners have distributed information to local faith community leaders and have enlisted their help in outreach efforts.

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Table 3.5

Type of coordination	School Lunch	Maternal and child health	Other (specify) Children with Special Health Care Services (a Title V supplementary program that provides medical assistance to families of children who have certain chronic medical conditions and who also meet medical and financial eligibility requirements)	Other (specify) ___ ____Indiana First Steps (a Part C, IDEA, early intervention system for infants and toddlers who have developmental delays).
Administration			The Children's Health Policy Board is responsible for directing the coordination of various aspects of Hoosier Healthwise, Children with Special Health Care Services, and First Steps programs.	The Children's Health Policy Board is responsible for directing the coordination of various aspects of Hoosier Healthwise, Children with Special Health Care Services, and First Steps programs.

Outreach	The application forms for the School Lunch program asks families to indicate whether or not they would like to receive information about Hoosier Healthwise. The requests for additional information are forwarded to the local Division of Family and Children offices.	MCH grantees document referrals to other programs on the encounter forms and enter that information into the project data base so that follow-up can be performed during the next visit. MCH also operates the Indiana Family Helpline which provides health care information and referrals through a toll free telephone number. The Family Helpline staff screen all clients for Hoosier Healthwise eligibility and provide appropriate referrals. Seven MCH clinics participate as Hoosier Healthwise enrollment centers.	Children with special medical needs and their siblings who are eligible for Medicaid are identified by the CSHCS care coordinator when the care coordinator first receives the case and also during the annual re-evaluation.	First Steps distributes information about the Hoosier Healthwise program.

Eligibility determination		The MCH program requires direct service grantees to facilitate their clients into Medicaid if they meet eligibility requirements. MCH uses a combined application form that also includes Hoosier Healthwise, CSHCS, and Indiana First Steps.	Children who apply for CSHCS must also apply for Medicaid and if they are found eligible, CSHCS becomes the payer of last resort. The CSHCS application form can also be used to apply for Hoosier Healthwise, Indiana First Steps and MCH.	Indiana First Steps uses a combined application form that also includes Hoosier Healthwise, CSHCS, and MCH.
Service delivery		Forty-two of the 50 MCH grantees are Medicaid providers.		
Procurement				
Contracting				
Data collection			The IndianaAIM system captures CSHCS claims information because CSHCS is the payer of last resort for children who are also enrolled Medicaid.	The IndianaAIM system captures First Steps claims information because First Steps is the payer of last resort for children who are also enrolled in Medicaid.
Quality assurance				
Other (specify) _____				

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

3.6 How do you avoid crowd-out of private insurance?

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

X Eligibility determination process:

___ Waiting period without health insurance (specify) _____
X Information on current or previous health insurance gathered on application (specify)

Applicants are required to indicate on the application whether or not they have health insurance. Children who have health insurance may be eligible for Title XIX Medicaid, but will not be considered for Title XXI Medicaid.

___ Information verified with employer (specify) _____
X Records match (specify)

Health Management Systems is an organization that contracts with the Indiana Medicaid fiscal agent (Electronic Data Systems) to match claims information from the IndianaAIM system with insurance coverage information from other private insurance providers. If they find that a Hoosier Healthwise member has private coverage, they charge the claim to the private insurance provider and notify the fiscal agent. The member's caseworker is notified by the fiscal agent.

___ Other (specify) _____
___ Other (specify) _____

___ Benefit package design:

___ Benefit limits (specify) _____
___ Cost-sharing (specify) _____
___ Other (specify) _____
___ Other (specify) _____

___ Other policies intended to avoid crowd out (e.g., insurance reform):

___ Other (specify) _____

___ Other (specify) _____

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

Crowd-out is being measured by monitoring the number of children with commercial health insurance who apply for Hoosier Healthwise. Applicants are required to indicate on the application whether or not they have commercial health insurance. Children who have commercial health insurance may be eligible for Title XIX Medicaid, but will not be considered for Title XXI Medicaid. Since implementation of the 1998 Title XXI Medicaid expansion, there has not been a major change in the percentage of children with commercial health insurance who have applied for Hoosier Healthwise. In May 1998, 11.5 percent of children enrolled in Hoosier Healthwise had commercial health insurance, and in comparison, 12.9 percent of children enrolled in September 1999 had commercial insurance.

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

Table 4.1.1 CHIP Program Type Medicaid Expansion

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	25,194	34,902	8.1	10.1	8,130	8,226
Age						
Under 1	NA	NA	NA	NA	NA	NA
1-5	1,062	2,833	2.8	10.1	62	624
6-12	3,516	9,901	2.7	9.5	189	1,586
13-18	20,616	22,168	9.5	10.5	7,879	6,016

Countable Income Level*						
At or below 150% FPL	25,194	34,902	8.1	10.1	8,130	8,226
Above 150% FPL	NA	NA	NA	NA	NA	NA
Age and Income						
Under 1						
At or below 150% FPL	NA	NA	NA	NA	NA	NA
Above 150% FPL	NA	NA	NA	NA	NA	NA
1-5						
At or below 150% FPL	1,062	2,833	2.8	10.1	62	624
Above 150% FPL	NA	NA	NA	NA	NA	NA
6-12						
At or below 150% FPL	3,516	9,901	2.7	9.5	189	1,586
Above 150% FPL	NA	NA	NA	NA	NA	NA
13-18						
At or below 150% FPL	20,616	22,168	9.5	10.5	7,879	6,016
Above 150% FPL	NA	NA	NA	NA	NA	NA
Type of plan						
Fee-for-service	4,756	5,683	10.4	7.4	2,056	1,020
Managed care	7,848	9,317	8.2	11.2	2,631	2,656
PCCM	12,590	19,902	7.2	10.4	3,443	4,550

*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

CHIP enrollment data from the IndianaAIM system indicate that during FFY 1998 there were 25,194 children enrolled in the Title XXI Medicaid expansion and in FFY 1999 there were 34,902 children enrolled. An additional 7,971 children enrolled in Medicaid, who otherwise would have satisfied the eligibility requirements for CHIP, had other health insurance coverage.

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

There are a number of other public programs in Indiana that provide health related services to children (See Attachment G). Division of Family and Children (DFC) caseworkers refer families for these services, where appropriate. As these child-related programs engage in outreach activities that target individuals eligible for the services they offer, they also strive to identify other programs for which the children may be eligible and to make the appropriate referrals.

The Healthy Families Indiana Program, a voluntary home visitation program, is designed to prevent child abuse and neglect by linking families to a variety of services, including child development, health care, and parent education programs. The Healthy Families Indiana Program strives to ensure that every child has a medical home and that every child has up to date immunizations. Healthy Families also makes referrals to Hoosier Healthwise and various other child-related programs in the State. Each individual community develops its own Healthy Families outreach plan.

The Children's Special Health Care Services (CSHCS) program is an insurance program that provides medical assistance to approximately 8,000 families of children who have certain chronic medical conditions and who also meet medical and financial eligibility requirements. Children are referred to the CSHCS program by providers and by other programs throughout the State. CSHCS requires that children who apply for the program also apply for Medicaid. Children with special medical needs and their siblings who are eligible for Medicaid are identified by the CSHCS care coordinator when the care coordinator first receives the case and also during the annual re-evaluation. Applications for the CSHCS program are taken by the newborn intensive care unit at Riley Hospital for Children, the only children's hospital in the State. To help identify eligible children and to

streamline administrative hurdles, the CSHCS program has developed a combined intake system with other public programs. Each county has a single point of entry which can take a combined Hoosier Healthwise, CSHCS, First Steps, and SSI application. This collaboration has resulted in a large increase in the number of children served by the CSHCS program.

The Indiana Maternal and Child Health (MCH) program requires direct service grantees to facilitate their clients into Medicaid if they meet eligibility requirements. Children under 100% of poverty are served free of charge. MCH funds 22 child or adolescent health clinics and 4 school based health clinics. Services for children are also provided at other MCH sites. Forty-two of the 50 MCH grantees are Medicaid providers, and several of these act as PMPs under Hoosier Healthwise. Each individual MCH grantee handles its own outreach and marketing. Grant applications address collaborative efforts. The MCH grantees also document referrals to other programs on the encounter forms and enter that information into the project data base, so that follow-up can be performed during the next visit.

The MCH program also operates the Indiana Family Helpline which provides health care information and referrals through a toll free telephone number. The Family Helpline staff screen all clients for Hoosier Healthwise eligibility and provide appropriate referrals. MCH clinics also participate as Hoosier Healthwise enrollment centers. The Helpline is advertised through flyers distributed throughout the State. The telephone number is also included in mailings which are sent to consumers by the Family and Social Services Administration (FSSA).

Indiana has a Step Ahead initiative which is designed to develop, at the local level, comprehensive seamless delivery systems for children from birth to age thirteen. The initiative is designed to support county efforts to centralize programs in order to reduce duplication and fragmentation of services. Local Planning Councils work to address child issues in the community. At the state level, Step Ahead strives to coordinate funding streams and remove barriers that create problems for families and providers.

First Steps, Indiana's early intervention system for infants and toddlers who have developmental delays, brings together federal, state, local, and private funding sources in order to create a coordinated, community-based system of services. In each community, a "child find" system is developed and is utilized to identify, locate and evaluate children who are eligible for early intervention services. Networks of traditional and non-traditional providers are established. Providers in the networks include MCH programs; community mental health centers; Women, Infants and Children (WIC) programs; developmental disabilities agencies; MCH agencies; CSHCS programs; private health care providers; child care providers; United Way agencies; and independent providers and service coordinators.

First Steps collaborates with the DFC by distributing information about the Hoosier Healthwise program.

Very important health care services for children are also provided by Community Health Centers (CHCs). These centers design their services around needs identified in their particular communities. Many of the CHCs engage in significant outreach activities and some serve as Hoosier Healthwise enrollment centers.

A Consolidated Outreach Project (COP) provides intake assessment for migrant farmworkers who enter Indiana for seasonal employment. The project is offered through a Federally Qualified Health Center (FQHC) and is funded by the Department of Education (DOE), Department of Workforce Development, the Social Services Block Grant, and the Community Services Block Grant. Through the COP project, families are referred to the various health care programs and other programs for services while they are in the state.

There are several current initiatives that provide health services to children through collaborative public and private efforts. These efforts include a collaboration between the Indiana State Department of Health (ISDH) and the Indiana Primary Health Care Association (IPHCA); managed care contracts between the Division of Mental Health (DMH) and managed care providers; and a health insurance high risk pool for medically challenged individuals that is financed through a partnership between the beneficiaries, the health insurance industry and the State.

Through a collaborative arrangement between the ISDH and the IPHCA, health care services are provided to children and other individuals throughout the State. This arrangement was designed to improve access to primary health care programs for the medically underserved; individuals at poverty level; working poor; migrant and seasonal farmworkers; the homeless; and individuals who lack health care due to geographic, financial and/or cultural barriers. The IPHCA also recently received a grant to promote the development of enrollment centers in FQHCs. This grant is used to augment the state outreach efforts.

The ISDH also worked collaboratively with IPHCA to allocate funds that the General Assembly earmarked for Community Health Centers (CHCs). Start-up and planning funds were provided in the 1995 biennium budget, and funds for expanding existing services, start-up and planning were provided in the 1997 and 1999 biennium budgets. Applicants for these funds were required to address community needs, special populations, and collaborative linkages. Overall, there are a approximately 35 state and/or federally funded CHCs in Indiana. In 1996, the federally funded sites alone served over 28,000 children. Over 4,000 of the individuals served by these FQHCs were migrant farmworkers. The 1996 data indicate that approximately 59 percent of the clients served at the FQHCs are Caucasian, 27 percent African-American, 14 percent Hispanic, and less than 1 percent

combined are Native American or Asian. The CHCs that are not federally funded also provide health services to the communities; however, such data are not currently available.

Many of the CHCs utilize outreach workers to market their services to potential clients in the individual communities. These outreach workers often go door to door to target potential clients. CHCs located in areas with high concentrations of Hispanics and migrant farm workers use Spanish speaking outreach workers and providers. As part of the COP partnership, the CHCs provide health services to migrant farmworkers.

The Division of Mental Health (DMH) has undertaken a collaborative effort with mental health providers throughout the state. The providers act as mini-HMOs in that they receive a payment up-front from the DMH, and, in return, provide a full array of mental health services to seriously emotionally disturbed children who are at 200 percent of poverty or below. The DMH is also involved in the Dawn Project, a collaborative effort with the DOE Division of Special Education, the Marion County Office of Family and Children, the Marion County Superior Court Juvenile Division and the Marion County Mental Health Association. The goal of this pilot project is to provide community based services to children and youth in Marion County who are seriously emotionally disturbed and who are at imminent risk of long-term inpatient psychiatric hospitalization or residential care. Families are assigned a service coordinator who works with the family to design an array of services that meet the individual needs of the child and family. Referrals to the program come primarily from the Office of Family and Children, the DOE and the Juvenile Court.

A partnership between the health insurance industry and the State is the underlying principle behind the financing of an insurance risk pool for medically challenged individuals who are unable to obtain traditional health insurance. The Indiana Comprehensive Health Insurance Association (ICHIA), a private non-profit association created by the Indiana General Assembly, covers more than 100 children. State programs make referrals to ICHIA where appropriate. ICHIA is funded through premiums, and an assessment on insurance companies licensed in the State. Since the insurance companies are able to obtain a State tax credit for these assessments, the State is an important partner in this initiative as well.

4.2 Who disenrolled from your CHIP program and why?

4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

In FFY 1998, 8,130 children disenrolled from the CHIP program, and in FFY 1999, 8,226 children disenrolled. The disenrollment figures for FFY 1998 constitute approximately 13 percent of the sum of the number of children ever enrolled in each quarter (64,246), and the

figures for FFY 1999 account for approximately 7 percent of the sum of the number of children ever enrolled in each quarter (111,600). These annual disenrollment rates were similar to the rates for traditional Medicaid, which were 18 percent in FFY 1998 and 5 percent in FFY 1999.

The similarity in disenrollment rates for CHIP and Medicaid are predictable because fluctuations in income are common among the eligible populations. Indeed, there is a great deal of movement between CHIP and Medicaid among children enrolled in the programs. Both programs grant 12 months of continuous eligibility to children enrolled, but due to changes in circumstances reported by the families during the continuous eligibility period, the children move between CHIP and Medicaid. Fortunately, the integration of these programs minimizes the impact of such transitions on families.

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?

Unfortunately, this information is not available for the period of time covered in this report.

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

Table 4.2.3

Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHIP Program* _____ _____	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total	16,356 (sum of number of disenrollees per quarter for FFY 1998 and FFY 1999 as indicated in HCFA quarterly reports)	9% (number of disenrollees as a percentage of the sum of the number of children ever enrolled per quarter in FFY 1998 and FFY 1999 as indicated in HCFA quarterly reports)				
Access to commercial insurance						
Eligible for Medicaid						
Income too high						
Aged out of program						
Moved/died						
Nonpayment of premium						
Incomplete documentation						
Did not reply/unable to contact						
Other (specify) _____						
Other (specify) _____						
Don't know	16,356	9%				

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

When a child disenrolls from the program because the family income exceeds the income eligibility requirements or the child has acquired other insurance coverage, the caseworker encourages the family to notify the local DFC office if there is a change in their circumstances that may make the child eligible once again.

Also, in some counties, if a caseworker is unable to locate a family to complete the redetermination process, the family's enrollment information is sent back to enrollment center where the original application was received so that the enrollment center may attempt to contact the family.

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 $27,316,224

FFY 1999 $57,458,450

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

Table 4.3.1 CHIP Program Type Medicaid Expansion

Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	$27,316,224	$57,458,450	$19,938,117	$41,778,039
Premiums for private health insurance (net of cost-sharing offsets)*	$0	$7,785,965	$0	$5,661,175
Fee-for-service expenditures (subtotal)	$27,316,224	$46,689,773	$19,938,117	$33,948,134
Inpatient hospital services	$4,691,826	$7,296,387	$3,424,564	$5,305,202

Inpatient mental health facility services	$1,579,021	$2,282,637	$1,152,527	$1,659,706
Nursing care services	$6,854,099	$9,014,952	$5,002,807	$6,554,772
Physician and surgical services	$1,845,838	$3,522,541	$1,347,277	$2,561,240
Outpatient hospital services	$1,476,843	$2,882,151	$1,077,948	$2,095,612
Outpatient mental health facility services	$3,960,059	$6,629,413	$2,890,447	$4,820,246
Prescribed drugs	$2,820,326	$5,530,579	$2,058,556	$4,021,283
Dental services	$1,311,355	$4,185,534	$957,158	$3,043,302
Vision services	$289,419	$558,863	$211,248	$406,350
Other practitioners' services	$109,394	$83,399	$79,847	$60,639
Clinic services	$455,203	$913,042	$332,253	$663,873
Therapy and rehabilitation services	$19,094	$121,215	$13,937	$88,135
Laboratory and radiological services	$345,847	$574,529	$252,434	$417,740
Durable and disposable medical equipment	$342,676	$857,798	$250,120	$623,705
Family planning*	$0	$0	$0	$0
Abortions*	$0	$0	$0	$0
Screening services	$39,985	$146,193	$29,184	$106,297
Home health	$477,847	$741,684	$348,781	$539,278
Home and community-based services	$0	$0	$0	$0
Hospice	$63,248	$0	$46,165	$0
Medical transportation	$142,185	$331,207	$103,781	$240,820
Case management	$149,858	$19,788	$109,382	$14,388
Other services	$342,101	$997,863	$249,700	$725,546

*The State receives a 90 percent federal match from non-Title XXI funds for these expenditures.

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap?_____

The State did not claim any administrative expenditures in FFY 1998. In FFY 1999, the funding available under the 10 percent limit was used for staff salaries, eligibility and claims payment systems modifications, claims processing, caseworker services, supplies and equipment, and travel.

The fund established by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) was used to pay for Hoosier Healthwise outreach activities.

What role did the 10 percent cap have in program design? _____

The 10 percent limit influenced the State's decision to implement a Medicaid expansion as the most cost-effective option. The expansion allowed the State to build on existing infrastructure and placed the State in a position to take advantage of combined purchasing and contracting.

Table 4.3.2

Type of expenditure	Medicaid Chip Expansion Program		State-designed CHIP Program		Other CHIP Program* _____ _____	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share	$0	$2,982,712				
Outreach						
Administration	$0	$2,982,712				
Other_____						
Federal share	$0	$2,168,730				
Outreach						
Administration	$0	$2,168,730				
Other _____ _____						

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

X State appropriations
___ County/local funds
___ Employer contributions
___ Foundation grants
___ Private donations (such as United Way, sponsorship)
X Other (specify) Tobacco Settlement

4.4 How are you assuring CHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in a Primary Care Case Management program, specify 'PCCM.'

Table 4.4.1

Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____ _____
Appointment audits	MCO, PCCM		
PCP/enrollee ratios	MCO, PCCM		
Time/distance standards	MCO, PCCM		
Urgent/routine care access standards	MCO, PCCM		
Network capacity reviews (rural providers, safety net providers, specialty mix)	MCO, PCCM		
Complaint/grievance/ disenrollment reviews	MCO, PCCM		
Case file reviews	MCO, PCCM		
Beneficiary surveys	MCO, PCCM		
Utilization analysis (emergency room use, preventive care use)	MCO, PCCM		
Other (specify) _____ _____			
Other (specify) _____ _____			
Other (specify) _____ _____			

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

Table 4.4.2

Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____ _____
Requiring submission of raw encounter data by health plans	X Yes ___ No	___ Yes ___ No	___ Yes ___ No
Requiring submission of aggregate HEDIS data by health plans	X Yes ___ No	___ Yes ___ No	___ Yes ___ No
Other (specify)_____ _____	___Yes ___ No	___ Yes ___ No	___ Yes ___ No

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

All children enrolled in Hoosier Healthwise select or are assigned to a primary medical provider (PMP) unless the child is a ward of the State, resides in an institution, requires a certain level of care, or lives in a medically underserved area that does not have a provider available to serve as the child's PMP. In June 1998, prior to the 1998 Title XXI Medicaid expansion, 15 percent of Hoosier Healthwise members were auto-assigned to a PMP. In comparison, only 8 percent of Hoosier Healthwise members were auto-assigned to a PMP in September 1999. Although the State did not achieve the goal of 95 percent PMP self-selection by September 30, 1999, the auto-assignment rate continues to decrease.

As of September 1999 there were 1,941 PMPs enrolled in Hoosier Healthwise. Between June 1998 and September 1999, 109 PMPs and 258 new dentists joined the program. In May 1998, there were PMPs in only 88 of the 92 counties. As of September 1999, there were PMPs in all 92 counties. Targeted recruitment efforts are currently being focused on several counties where the State wants to increase the numbers of PMPs serving the county. For these counties, new enrollees may either remain in the fee for service program where they can access any Medicaid enrolled physician, or choose PMPs in contiguous counties.

The 1998 Hoosier Healthwise Member Satisfaction Survey revealed that 89 percent of members surveyed had visited their doctor within 6 months of the survey, more than two-thirds (64%) of members surveyed considered their health status to be much better or somewhat better than before enrolling in Hoosier Healthwise, and 89 percent of members surveyed indicated that their accessibility to specialty care was available when needed (see Attachment D).

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

The Indiana Family and Social Services Administration and the Indiana State Department of Health are collaborating to identify medically under-served areas for Hoosier Healthwise, assess current provider recruitment efforts and develop new county-specific approaches.

The State will also be contracting with an independent evaluator to evaluate the entire CHIP program, including access to care. The evaluator's first annual report should be available in March 2001.

4.5 How are you measuring the quality of care received by CHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.'

Table 4.5.1

Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Focused studies (chart reviews to determine immunization and well-child visit rates)	MCO, PCCM		
Client satisfaction surveys	MCO, PCCM		
Complaint/grievance/ disenrollment reviews	MCO, PCCM		
Sentinel event reviews			
Plan site visits			
Case file reviews			
Independent peer review			

HEDIS performance measurement	MCO		
Other performance measurement (specify)			

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

The Hoosier Healthwise Childhood Immunization Year One Focus Study revealed that immunization rates for children enrolled in Hoosier Healthwise did not meet the *Healthy People 2000* objectives (see Attachment C). Several factors that may have contributed to the rates being below the goal have since been identified. Inconsistent charting and poor documentation of immunizations given, or immunization records received from other physicians, made it difficult in many instances to verify that one or more immunizations had been given. Also, the number of children with up-to-date immunizations may be greater than counted because out-of-plan immunizations were not always captured in the PMP's medical records. Strategies are being designed to address these issues and improve levels of immunization in the future.

Also, the 1998 Hoosier Healthwise Member Satisfaction Survey found that 71 percent of members surveyed gave "very good" ratings for quality of care.

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

The Hoosier Healthwise focus studies are being revised and beginning in the year 2000 will use HEDIS measures instead of state-designed measures to facilitate comparisons across the managed care delivery systems.

The State will also be contracting with an independent evaluator to evaluate the entire CHIP program, including quality of care. The evaluator's first annual report should be available in March 2001.

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

Attachment C – 1998 Hoosier Healthwise Childhood Immunization – Year One Focus Study Results

Attachment D – 1998 Hoosier Healthwise Member Satisfaction Survey Briefing Paper

Attachment E – 1998 Hoosier Healthwise Primary Medical Provider Satisfaction Survey Briefing Paper
Attachment F – Hoosier Healthwise Performance Update September 1999
Attachment G – Children's Programs in Indiana

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

5.1.1 Eligibility Determination/Redetermination and Enrollment

By utilizing and building on the existing eligibility determination and enrollment procedures for Hoosier Healthwise, the State was able to implement the first phase of Indiana's CHIP program in a manner that minimized confusion among providers and members, maximized cost-efficiency, and encouraged the de-stigmatization of Medicaid. Rather than create a new, more respectable program and ignore the stigma associated with Medicaid, the State used CHIP as a catalyst to change the perception of Medicaid. Specifically, Indiana has engaged in the following activities to de-stigmatize participation in Medicaid and CHIP, and change the perception of both programs from public assistance to health insurance:

- Almost 500 enrollment centers were established and mail-in applications with telephone interviews were made available to give families choices other than going to a Division of Family and Children (DFC) office to enroll;
- Local DFC offices were given Hoosier Healthwise enrollment goals to encourage caseworkers to enroll children and create a friendly environment for families;
- Each local DFC office was required to develop a county-specific outreach plan for meeting the enrollment goal;
- The Hoosier Healthwise application and documentation requirements were simplified;
- Targeted outreach plans for minority populations were implemented;
- The old Indiana Medicaid card was replaced with a blue and gold Hoosier Health Card that resembles a commercial insurance card;
- Hoosier Healthwise was redefined to include coverage for all children enrolled in Medicaid or CHIP, and is referred to as health insurance rather than public assistance; and
- Children enrolled in Hoosier Healthwise are referred to as members rather than recipients, and materials distributed to providers have been changed to reflect this change.

The State is also piloting enrollment strategies in eight communities on a three-year Robert Wood Johnson Covering Kids grant which targets hard to reach populations. Eight local coalitions are implementing innovations to identify and enroll the hardest to serve populations. The three-year project will allow for pilot testing of new strategies, including electronic applications completed in clients' homes, partnering with schools, and enrollment in various offices that serve eligible families.

5.1.2 Outreach

The Hoosier Healthwise enrollment increase is the clearest evidence that the comprehensive outreach campaign implemented in conjunction with the Medicaid expansion has been a tremendous success. The development of community-based outreach plans that reflect the unique needs and interests of each county has encouraged the formation of local partnerships which have been vital to the identification of potentially eligible children and the distribution of marketing materials.

The development of specific outreach strategies for traditionally underserved minority populations has also been fundamental to the success of the campaign. By contracting with minority community partners, the State has been able to leverage their understanding of specific minority populations and implement successful, targeted outreach activities.

The combination of local outreach strategies with statewide marketing activities has revolutionized the way families access public health services in Indiana.

5.1.3 Benefit Structure

The State is satisfied that the health benefits available to children enrolled in CHIP are comprehensive and provide children with access to primary, preventive, acute and long-term care services. Through EPSDT screenings, enrolled children have access to all Medicaid-provided services, as well as any other services that are deemed medically necessary for the health of the child. The availability of generous enabling services, and supplementary services through other programs, such as Indiana's First Steps program or Indiana's Title V program, ensure that additional health services for children with special health care needs are also accessible.

To ensure that children with special health care needs are informed about the availability of supplementary services, the State is including information about Indiana's Title V program and the First Steps program in materials distributed to providers, and is utilizing the Benefit Advocates to provide families with information about the programs when they apply for Hoosier Healthwise. Also, Indiana University and the Indiana Parent Information Network have been awarded a grant from the Agency for Healthcare Research and Quality, the David and Lucille Packard Foundation, and the Health Resources and Services Administration to work in coordination and collaboration with the State to evaluate and compare access
and quality of care for CHIP members with special health care needs enrolled in the Hoosier Healthwise managed care delivery systems.

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)

NA

5.1.5 Delivery System

By utilizing the existing Hoosier Healthwise delivery systems, the Medicaid expansion was implemented with minimal disruption for providers and families. Both the Primary Care Case Management system and the Risk-Based Managed Care system provide members with a Primary Medical Provider (PMP) to serve as a medical home and coordinate members' care by providing preventive and primary medical care, and furnishing authorizations and referrals for most specialty services. By integrating children eligible for Medicaid through the Title XXI expansion into these managed care networks, continuity of care is protected for children who move between Title XIX and Title XXI.

The decision to use the existing delivery systems also provided an incentive to improve access for all children enrolled in Hoosier Healthwise. Strategies have been implemented to encourage PMP self-selection and decrease the auto-assignment rate, and increase the number of PMPs participating in Hoosier Healthwise. Since the Medicaid expansion began, we have already enjoyed significant success with these initiatives, as indicated in the 1998 Hoosier Healthwise Member Satisfaction and Primary Medical Provider Satisfaction surveys.

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

As part of the outreach campaign, Indiana has made considerable efforts to coordinate the CHIP program with existing public programs. A central theme underlying the Division of Family and Children's (DFCs) efforts to develop different enrollment center models was the importance of utilizing and building upon resources and programs from within each individual community. While local DFC directors were given considerable flexibility in fashioning enrollment center designs that are appropriate for the specific enrollment centers, they were also required to consult with a myriad of entities in their community. These organizations included: Head Start, First Steps, community action programs, community health centers, childcare voucher agents, disproportionate share hospitals, WIC clinics, MCH clinics, county health departments, Planned Parenthood, schools and township trustees.

The Indiana Department of Education (DOE) includes a check-off box on its school lunch application form that allows families to communicate their interest in learning more about the Hoosier Healthwise program. This also serves as a means for enabling families to authorize the DOE to relay, to the DFC, the families' interest in the program. Many other programs in the State also collaborate with the DFC by distributing information about the Hoosier Healthwise program, educating families, and making referrals. These programs include: Head Start community mental health centers, energy assistance, IMPACT (welfare to work), child welfare, and domestic violence programs. Collaborations have also been undertaken with the Department of Workforce Development, the DOE, the Bureau of Motor Vehicles, the Department of Commerce, and the Juvenile Justice Institute. In addition, many State health and human service contractors also are required to inform families about the Hoosier Healthwise program, distribute program brochures, and refer families to the Helpline.

While these collaborative efforts have contributed to the identification of potentially eligible children, other strategies are being pursued to coordinate the eligibility determination, enrollment and claims payment processes of health-related programs for children. Coordination of these programs will allow the state to: 1) more effectively locate and enroll eligible children; 2) provide seamless service to families, even if the family is served by different programs and/or agencies; and 3) maximize federal, state and local funding in order to serve as many eligible children as possible, while meeting the goals of each individual program.

Although there are many programs available to children in the state with similar eligibility requirements (see Attachment G), families and caseworkers of children enrolled in a single program, who are also eligible for other programs, are often not aware that the programs exist or of the eligibility requirements. This is especially frustrating for families of children with special needs. Thus, Public Law 273-1999 established the Children's Health Policy

Board, consisting of various agency heads, to oversee implementation of CHIP and direct the coordination of children's health programs in Indiana. The Board has contracted with a consultant who will recommend options for the coordination of the eligibility determination, enrollment and claims payment processes of children's health programs. The contractor will submit a final report to the Board in August 2000.

Public Law 273-1999 also created an Advisory Committee for Children with special health care needs. One of the functions of the Advisory Committee is to advise and assist the Policy Board in developing, coordinating and evaluating policies that impact children with special needs, and to provide assistance with the integration of services.

5.1.7 Evaluation and Monitoring (including data reporting)

The first phase of CHIP has been incorporated into existing evaluation and monitoring activities for Hoosier Healthwise. Due to the relatively small CHIP population (25,194 children in FFY 1998 and 34,902 children in FFY 1999) only expenditure and enrollment data for CHIP have been collected separately from information regarding Title XIX Hoosier Healthwise members. As the CHIP population grows, additional information, such as member and PMP satisfaction, immunization and well-child visit rates, and other performance measures, will be examined independently. Until then, we are in the process of examining ways of improving our current evaluation and monitoring activities. In particular, we are analyzing the manner in which CHIP enrollment data is captured by the IndianaAIM system in an attempt to remedy the problem of underreporting newly enrolled children.

The state has also awarded a contract for an independent evaluation of Phase I and II of CHIP. The evaluator will be developing and implementing performance criteria and evaluation measures to:

- assess the effectiveness of CHIP in reducing the number of uninsured, low-income children and increasing the number of children with creditable health coverage;
- measure the extent to which CHIP is being substituted for other public and private health insurance programs available in the state;
- determine how effectively CHIP is addressing the health care needs of uninsured, low-income children;
- measure the quality of health coverage provided by CHIP by monitoring the services rendered by participating providers, including managed care organizations;
- determine how often, how effectively, and how appropriately enrollees are utilizing health care services;
- develop and monitor health status indicators for children enrolled in the program;
- measure the extent to which children enrolled in the program are receiving early

screening, diagnosis and treatment services in accordance with the HealthWatch Indiana EPSDT Program Periodicity and Screening Schedule; and
- analyze changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.

5.1.8 Other (specify)

NA

5.2 What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

On January 1, 2000, the second phase of CHIP began with the introduction of a state-designed program that provides coverage to uninsured children less than 19 years of age who are members of families with annual incomes greater than 150 percent of the federal poverty level and not more than 200 percent of the federal poverty level. It is estimated that 40,000 children throughout the state will eventually enroll in the program.

Although Phase II has different eligibility criteria, a separate benefits package, and involves cost sharing, the administration of the program is closely aligned with that of the Medicaid program. The second phase of CHIP is administered as part of the Hoosier Healthwise program and is referred to as "Hoosier Healthwise Package C – Children's Health Plan." Package C utilizes the same eligibility determination, enrollment, provider network and claims payment systems that are used by the Medicaid, and thereby reduces administrative hurdles and duplicity, and maximizes coverage and coordination.

As a result of the 2000 expansion, Hoosier Healthwise has been restructured to include five benefit packages and more closely resemble private insurance. Children who qualify for Title XIX or the Title XXI Medicaid expansion are enrolled in "Hoosier Healthwise Package A – Standard Plan," and children who qualify for CHIP Phase II are enrolled in Package C.

The Children's Health Policy Board has selected a contractor to evaluate and recommend options that the state may pursue to provide coverage to additional uninsured populations. Specifically, the contractor will conduct an analysis of the feasibility of expanding health insurance programs currently available in Indiana that will include the following:

- An inventory of Indiana's levels of health care coverage, both public and private;
- An assessment of the types of health care coverage currently available to Indiana residents;
- A report on other states' efforts to expand health care coverage;
- Options for expanding health care coverage to Indiana's uninsured populations;
- An assessment of the economic impact to the State of expanding health care coverage:
- The budget implications of various expansion options; and

- Final recommendations for expanding health care coverage to Indiana's uninsured populations.

The contractor will submit a final report to the Board in September 2000.

As mentioned in Section 5.1.6., the Board has also selected a contractor to develop recommendations that will enable simplified access to children's health programs through coordinated eligibility determination and claims payment processes that are easily understood, widely available, and family friendly. Specifically, the contractor will provide the following information and recommendations regarding eligibility for Indiana's children's health programs:

- A complete inventory of Indiana children's health programs' eligibility requirements;
- The number of eligible children served by the programs, and the estimated percentage actually served of total eligible population;
- The estimated numbers of families requiring and eligible for services from more than one of the programs;
- The degree of overlap and/or redundant services between children's programs;
- A description of current eligibility coordination processes, their strengths and weaknesses, and recommended measures to improve current coordination processes;
- Potential points of additional coordination which can improve access to services;
- Legal, regulatory and funding issues involved in improving eligibility coordination;
- Budget implications of additional coordination; and
- Standards for eligibility determination program design.

The contractor will also provide the following information and recommendations regarding seamless claims payments for Indiana's children's health programs:

- A complete inventory of Indiana children's health programs' claims payment systems;
- A description of provider participation in each program;
- Numbers and types of providers serving more than one program;
- The degree of overlap and/or redundant services generated by the current systems of claims payment;
- A comparison of rates of reimbursement of various programs;
- An assessment of the accuracy and timeliness of the reimbursement system of each program;
- Measures to improve claims payment coordination;
- Legal, regulatory and funding issues involved in improved claims payment coordination;
- Budget implications of improved claims payment coordination; and
- Standards for improved claims payment systems program design.

The contractor will submit a final report to the Board in August 2000.

5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

The introduction of several modifications to the program at the federal level would greatly enhance the ability of states to provide appropriate health coverage to all eligible children. By excluding state-designed CHIP programs from the drug rebate program, states that pursue creative means of providing non-Medicaid health care to children, but do not have significant managed care penetration are penalized. As prescription drug utilization and costs increase, the ability of states to maintain or expand their CHIP programs is jeopardized.

The financial health of CHIP programs would also be more secure if the allocation of federal funding were based on more accurate data. The CPS sample size in Indiana is quite small and therefore is unlikely to provide an accurate reflection of Indiana's uninsured population. The State has determined that it is necessary to conduct our own statewide survey of the uninsured to obtain a more accurate baseline estimate of uninsured low-income children. To remedy this situation, the federal government should 1) base CHIP funding on the results of state-sponsored surveys, 2) commission its own state surveys, or 3) like Medicaid expansion programs, allow state-designed CHIP programs to access federal Medicaid funds once the CHIP allocation has been exhausted.

States have been strongly encouraged by HCFA and other organizations to develop and implement aggressive outreach strategies. Yet, the federal funding available to conduct outreach activities is limited by their inclusion in the 10 percent limit. While we appreciate the flexibility that HCFA has demonstrated regarding the use of PRWORA and TANF funds, we are concerned that additional outreach activities and funds will be necessary as eligibility for CHIP is expanded to include children in families with higher incomes.

State efforts to coordinate CHIP with other children's health programs would be facilitated by greater coordination among health-related programs at the federal level. Increased coordination of multiple funding sources would allow states to avoid duplication, maximize resources and ensure that more children have access to health care. Specifically, standardization of eligibility and reimbursement guidelines across programs, assistance with confidentiality issues for data-sharing across programs, and coordination with Women, Infant and Children program enrollment would bolster state coordination efforts.

Addendum to Table 3.1.1

The following questions and tables are designed to assist states in reporting countable income levels for their Medicaid and SCHIP programs and included in the NASHP SCHIP Evaluation Framework (Table 3.1.1). This technical assistance document is intended to help states present this extremely complex information in a structured format.

The questions below ask for countable income levels for your Title XXI programs (Medicaid SCHIP expansion and State-designed SCHIP program), as well as for the Title XIX child poverty-related groups. Please report your eligibility criteria as of **September 30, 1999.** Also, if the rules are the same for each program, we ask that you enter duplicate information in each column to facilitate analysis across states and across programs.

If you have not completed the Medicaid (Title XIX) portion for the following information and have passed it along to Medicaid, please check here and indicate who you passed it along to. Name_____, phone/email_____

3.1.1.1 For each program, do you use a gross income test or a net income test or both?

Title XIX Child Poverty-related Groups	____Gross	X Net	____Both
Title XXI Medicaid SCHIP Expansion	____Gross	X Net	____Both
Title XXI State-Designed SCHIP Program	____Gross	____Net	____Both
Other SCHIP program_____	____Gross	____Net	____Both

3.1.1.2 What was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately.

Title XIX Child Poverty-related Groups	150 % of FPL for children under age 1
	133 % of FPL for children aged 1 through 5
	100 % of FPL for children aged 6 through 18
Title XXI Medicaid SCHIP Expansion	150 % of FPL for children aged 1 through 18
	____% of FPL for children aged _____
	____% of FPL for children aged _____

Title XXI State-Designed SCHIP Program ____% of FPL for children aged _____

____% of FPL for children aged _____

____% of FPL for children aged _____

Other SCHIP program_____ ____% of FPL for children aged _____

____% of FPL for children aged _____

____% of FPL for children aged _____

3.1.1.3 Complete Table 1.1.1.3 to show whose income you count when determining eligibility for each program and which household members are counted when determining eligibility? (In households with multiple family units, refer to unit with applicant child)

Enter "Y" for yes, "N" for no, or "D" if it depends on the individual circumstances of the case.

Table 3.1.1.3

Family Composition	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Child, siblings, and legally responsible adults living in the household*	Y	Y		
All relatives living in the household	N	N		
All individuals living in the household	N	N		
Other (specify)	N	N		

* Although a sibling's income may be counted when determining eligible for Hoosier Healthwise, a sibling's income cannot make a child ineligible for the program.

3.1.1.4 How do you define countable income? For each type of income please indicate whether it is counted, not counted or not recorded. ***Enter "C" for counted, "NC" for not counted and "NR" for not recorded.***

Table 3.1.1.4				
Type of Income	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings Earnings of dependent children	C	C		
Earnings of students	C	C		
Earnings from job placement programs	C	C		
Earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g., Serve America)	NC	NC		
Earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista)	NC	NC		
Education Related Income Income from college work-study programs	NC if funded under Title IV of Higher Education Act	NC if funded under IV of Higher Education Act		
Assistance from programs administered by the Department of Education	NC if funded under Title IV of Higher Education Act	NC if funded under Title IV of Higher Education Act		
Education loans and awards	NC (Awards not counted if funded	NC (Awards not counted if funded		

	under Title IV of Higher Education Act)	under Title IV of Higher Education Act)		
Other Income Earned income tax credit (EITC)	NC	NC		
Alimony payments received	C	C		
Child support payments received	C	C		
Roomer/boarder income	NC	NC		
Income from individual development accounts	C	C		
Gifts	NC	NC		
In-kind income	NC	NC		
Program Benefits Welfare cash benefits (TANF)	NC	NC		
Supplemental Security Income (SSI) cash benefits	NC	NC		
Social Security cash benefits	C	C		
Housing subsidies	NC	NC		
Foster care cash benefits	NC	NC		
Adoption assistance cash benefits	NC	NC		
Veterans benefits	C	C		
Emergency or disaster relief benefits	NC	NC		
Low income energy assistance payments	NC	NC		
Native American tribal benefits	NC	NC		
Other Types of Income (specify)	NC	NC		

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.1.5 What types and *amounts* of disregards and deductions does each program use to arrive at total countable income?

Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA."

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes X No

If yes, please report rules for applicants (initial enrollment).

Table 3.1.1.5

Type of Disregard/Deduction	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings	$90	$90	$	$
Self-employment expenses	40% of gross income	40% of gross income	$	$
Alimony payments Received	$0	$0	$	$
Paid	$0	$0	$	$
Child support payments Received	$50	$50	$	$
Paid	$0	$0	$	$
Child care expenses	$200 if child is under 2 years of	$200 if child is under 2 years of	$	$

	age $175 if child is 2 years of age or older	age $175 if child is 2 years of age or older		
Medical care expenses	$0	$0	$	$
Gifts	$0	$0	$	$
Other types of disregards/deductions (specify)	$0	$0	$	$

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.1.6 For each program, do you use an asset or resource test?

Title XIX Poverty-related Groups X No ____Yes (complete column A in 3.1.1.7)

Title XXI SCHIP Expansion program X No ____Yes (complete column B in 3.1.1.7)

Title XXI State-Designed SCHIP program ____No ____Yes (complete column C in 3.1.1.7)

Other SCHIP program_____ ____No ____Yes (complete column D in 3.1.1.7)

3.1.1.7 How do you treat assets/resources?

Please indicate the countable or allowable level for the asset/resource test for each program and describe the disregard for vehicles. If not applicable, enter "NA."

Table 3.1.1.7 Treatment of Assets/Resources	Title XIX Child Poverty-related Groups (A)	Title XXI Medicaid SCHIP Expansion (B)	Title XX designed Progr (C
Countable or allowable level of asset/resource test	$	$	$
Treatment of vehicles: Are one or more vehicles disregarded? *Yes or No*			
What is the value of the disregard for vehicles?	$	$	$
When the value exceeds the limit, is the child ineligible("I") or is the excess applied ("A") to the threshold allowable amount for other assets? *(Enter I or A)*			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.1.8 Have any of the eligibility rules changed since September 30, 1999? ___ Yes X No